Date: ____________

CONFIDENTIAL

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM – ADULT

Patient's Last Name: ________________________ First Name: ________________________ Middle Name/Initial: _____

Birth Date: __________ Age: _____ Sex: Male ☐ Female ☐ I Prefer To Be Called: ____________________

S.S.N./S.I.N.: ______________ Home Phone No.: (___)___-____ E-mail address: ______________________________________

Cell phone number:____________________Pager number:__________________

Patient's Address: ____

City: ____________________________ State/Province: _____ Zip/Postal Code: ______________

Years at above address: ____

If less than 5 years at current address, previous address:____

Years at previous address: _____ Patient is: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _________________________ Employer:_____________________________ Years with Employer: ____

Business Phone No.: (_____)______-______

Name Of Spouse/Closest Relative: _____________________________ Phone No.: (if different than yours) (_____)______-______

Relationship To You: _______________________

Address (if different than yours): ____

City: _____________________________ State/Province: _____ Zip/Postal Code: ______________

Name Of Patient's Dentist: ________________________________ Phone No.: (_____)______-______

Dentist's Address: ____

City: ______________________________ State/Province: _____ Zip/Postal Code: ______________

Date Last Seen: ______________ Reason: ____

Name Of Patient's Physician(s): _____________________________________ Phone No(s).: (___)____-____

Physician's Address: ____

City: ____________________________ State/Province: _____ Zip/Postal Code: _________

Date Last Seen: _______________ Reason: ______________________________________

Who suggested that you might need orthodontic treatment? __________________________

Why did you select our office? ____

Who Is Financially Responsible For This Account?

Last Name: _____________________________ First Name: ______________________ Middle Name/Initial: _____

Address (if different than patient's)____ Phone No.: (_____)______-______

City: ________________________________ State/Province: _________ Zip/Postal Code: ____________

Insurance Coverage For Dental Treatment? Yes ☐ No ☐ Insurance Coverage For Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name: ____-______________ S.S.N./S.I.N.: _________________

Birth Date: __________ Employed By: ____

Dental Insurance Company: ____ Group No. ________________________

Secondary Policy Holder's Name: ____________________________________ S.S.N./S.I.N.: ____________________________

Birth Date: __________ Employed By: ____

Dental Insurance Company: ____ Group No. __________________________

Medical Insurance Company: ______________________________

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

Now or in the past, have you had:

- ☐yes ☐no ☐dk/u Birth defects or hereditary problems?
- ☐yes ☐no ☐dk/u Bone fractures, any major accidents?
- ☐yes ☐no ☐dk/u Rheumatoid or arthritic conditions?
- ☐yes ☐no ☐dk/u Endocrine or thyroid problems?
- ☐yes ☐no ☐dk/u Kidney problems?
- ☐yes ☐no ☐dk/u Diabetes?
- ☐yes ☐no ☐dk/u Cancer, tumor, radiation treatment or chemotherapy?
- ☐yes ☐no ☐dk/u Stomach ulcer or hyperacidity?
- ☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- ☐yes ☐no ☐dk/u Problems of the immune system?
- ☐yes ☐no ☐dk/u AIDS or HIV positive?
- ☐yes ☐no ☐dk/u Hepatitis, jaundice or liver problem?
- ☐yes ☐no ☐dk/u Fainting spells, seizures, epilepsy or neurological problem?
- ☐yes ☐no ☐dk/u Mental health disturbance or depression?
- ☐yes ☐no ☐dk/u Vision, hearing, tasting or speech difficulties?
- ☐yes ☐no ☐dk/u Loss of weight recently, poor appetite?
- ☐yes ☐no ☐dk/u History of eating disorder (anorexia, bulimia)?
- ☐yes ☐no ☐dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- ☐yes ☐no ☐dk/u High or low blood pressure?
- ☐yes ☐no ☐dk/ u Tired easily?
- ☐yes ☐no ☐dk/u Chest pain, shortness of breath or swelling ankles?
- ☐yes ☐no ☐dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- ☐yes ☐no ☐dk/u Skin disorder?
- ☐yes ☐no ☐dk/u Do you have a well-balanced diet?
- ☐yes ☐no ☐dk/u Frequent headaches, colds or sore throats?
- ☐yes ☐no ☐dk/u Eye, ear, nose or throat condition?
- ☐yes ☐no ☐dk/u Hayfever, asthma, sinus trouble or hives?
- ☐yes ☐no ☐dk/u Tonsil or adenoid conditions?
- ☐yes ☐no ☐dk/u Osteoporosis?

Allergies or reactions to any of the following:

- ☐yes ☐no ☐dk/u Local anesthetics (Novocaine or Lidocaine)
- ☐yes ☐no ☐dk/u Aspirin
- ☐yes ☐no ☐dk/u Ibuprofen (Motrin, Advil)
- ☐yes ☐no ☐dk/u Penicillin or other antibiotics
- ☐yes ☐no ☐dk/u Sulfa drugs
- ☐yes ☐no ☐dk/u Codeine or other narcotics
- ☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)
- ☐yes ☐no ☐dk/u Latex (gloves, balloons)
- ☐yes ☐no ☐dk/u Vinyl
- ☐yes ☐no ☐dk/u Acrylic
- ☐yes ☐no ☐dk/u Animals
- ☐yes ☐no ☐dk/u Foods (specify) ______________________________
- ☐yes ☐no ☐dk/u Other substances (specify) ______________________

- ☐yes ☐no ☐dk/u Are you currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/cancers: such as Zometa (zolendronic acid), Aredia (pamidronate), Didronel (etidronate)?
- ☐yes ☐no ☐dk/u Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses: such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate) Skelid (tiludronate), Didronel (etidronate)?
- ☐yes ☐no ☐dk/u Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

- ☐yes ☐no ☐dk/u Do you currently have or ever had a substance abuse problem?
- ☐yes ☐no ☐dk/u Do you chew or smoke tobacco?
- ☐yes ☐no ☐dk/u Operations? Describe: ____________________
- ☐yes ☐no ☐dk/u Hospitalized? For: ______________________
- ☐yes ☐no ☐dk/u Other physical problems or symptoms? Describe: ______
- ☐yes ☐no ☐dk/ u Being treated by another health care professional? For: ____________________________ Date of most recent physical exam? _____________

Do you have any other medical conditions that we should know about?

____

WOMEN ONLY

- ☐yes ☐no ☐dk/u Are you pregnant?
- ☐yes ☐no ☐dk/u Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain.

Bleeding disorders______________________________________

Diabetes______________________________________

Arthritis______________________________________

Severe allergies______________________________________

Unusual dental problems______________________________________

Jaw size imbalance______________________________________

Any other family medical conditions that we should know about? _________

DENTAL HISTORY

Now or in the past, has the patient had:

☐**yes** ☐**no** ☐**dk/u** Permanent or "extra" (supernumerary) teeth removed?

☐**yes** ☐**no** ☐**dk/u** Supernumerary (extra) or congenitally missing teeth?

☐**yes** ☐**no** ☐**dk/u** Chipped or otherwise injured primary (baby) or permanent teeth?

☐**yes** ☐**no** ☐**dk/u** Teeth sensitive to hot or cold; teeth throb or ache?

☐**yes** ☐**no** ☐**dk/u** Jaw fractures, cysts or mouth infections?

☐**yes** ☐**no** ☐**dk/u** "Dead teeth" or root canals treated?

☐**yes** ☐**no** ☐**dk/u** Bleeding gums, bad taste or mouth odor?

☐**yes** ☐**no** ☐**dk/u** Periodontal "gum problems"?

☐**yes** ☐**no** ☐**dk/u** Food impaction between teeth?

☐**yes** ☐**no** ☐**dk/u** "Gum boils", frequent canker sores or cold sores?

☐**yes** ☐**no** ☐**dk/u** Thumb, finger, or sucking habit? Until what age ________?

☐**yes** ☐**no** ☐**dk/u** Abnormal swallowing habit (tongue thrusting)?

☐**yes** ☐**no** ☐**dk/u** History of speech problems?

☐**yes** ☐**no** ☐**dk/u** Mouth breathing habit, snoring or difficulty in breathing?

☐**yes** ☐**no** ☐**dk/u** Tooth grinding or jaw clenching?

☐**yes** ☐**no** ☐**dk/u** Any pain, clicking or locking in jaw or ringing in the ears?

☐**yes** ☐**no** ☐**dk/u** Any pain or soreness in the muscles of the face or around the ears?

☐**yes** ☐**no** ☐**dk/u** Difficulty in chewing or jaw opening?

☐**yes** ☐**no** ☐**dk/u** Have you ever been treated for "TMD" or "TMJ" problems?

☐**yes** ☐**no** ☐**dk/u** Aware of loose, broken or missing restorations (fillings)?

☐**yes** ☐**no** ☐**dk/u** Any teeth irritating cheek, lip, tongue or palate?

☐**yes** ☐**no** ☐**dk/u** Concerned about spaced, crooked or protruding teeth?

☐**yes** ☐**no** ☐**dk/u** Aware or concerned about under or over developed jaw?

☐**yes** ☐**no** ☐**dk/u** Any relative with similar tooth or jaw relationships?

☐**yes** ☐**no** ☐**dk/u** Any wisdom tooth problems?

☐**yes** ☐**no** ☐**dk/u** Had periodontal (gum) treatment?

☐**yes** ☐**no** ☐**dk/u** Had any serious trouble associated with any previous dental treatment?

☐**yes** ☐**no** ☐**dk/u** Been under another dentist's care?
Specialist ______________________________
Other ______________________________

☐**yes** ☐**no** ☐**dk/u** Ever had a prior orthodontic examination or treatment?

☐**yes** ☐**no** ☐**dk/u** Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: _____ floss: _____

What is your primary concern? Why are you here? ____

Questions: ____

DOCTOR CONTACT INFORMATION

Doctor's Last Name: ____________________ First Name: ____________________ Middle Name/Initial: _____

Office Phone No.: (___) ___-____ E-mail address: ______________________________

Doctor's Address: ____

City: ____________________ State/Province: __________ Zip/Postal Code: ____________

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: ____ Date Signed: ______________
(Patient)

Signed: ____ Date Signed ______________
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

Signed: ____ Date Signed: ______________
(Patient)
Signed:____ Date Signed: ______________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

Signed: ____ Date Signed: ______________
(Patient)

Signed:____ Date Signed: ______________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____

Signed: ____ Date Signed: ______________
(Patient)
Signed:____ Date Signed: ______________
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: ____
Signed: ____ Date Signed: ______________
(Patient)
Signed:____ Date Signed: ______________
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